STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

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{E 000}	Initial Comments An unannounced Emergency Preparedness revisit to the standard survey conducted 7/24/19 through 7/26/19 was conducted 9/4/19 through 9/5/19. The facility was found to be in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 7/24/19 through 7/26/19, was conducted 9/4/19 through 9/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Two complaints were investigated during the survey. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents #101 and #103 through #115) and 1 closed record review (Resident #102).	{F 000}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	{F 657}		9/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/18/2019

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{F 657}	Continued From page 1 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to revise a person-centered comprehensive care plan for 1 of 15 residents in the survey sample, Resident # 105. The findings included: Resident #105 was admitted to the facility on 12/15/18 with diagnosis to include, but not limited to diabetes. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 8/16/19 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident was coded as having received insulin 7 out of 7 days in the look back period. Section E. Behaviors did not code the resident as having rejection of care to include taking medications.	{F 657}	1. Care plan for resident #105 was updated to include the refusal of insulin and blood sugars. 2. 100% audit of residents with behaviors of refusing medications, treatments to identify other residents at risk for this issue. 3. Education by DON or designee for licensed nursing staff on updating care plans regarding refusal of care, medications and treatment. Education by DON or designee for MDS staff on updating care plans regarding refusals of care, medications and treatments. 4 Audit by DON or designee 5 times a week x 12 weeks for revisions related to refusal of care, medications or treatments.	

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{F 657}	Continued From page 2 The resident's person-centered comprehensive care plan dated 5/14/19 identified a focus area of diabetes and the resident was at risk for low and/ or high blood sugar. The goal was that the resident would be free of low and or high blood sugars through the next review date of 11/14/19. One of the interventions listed to achieve/maintain the goal was to administer medications as ordered. The care plan did not include refusals of insulin. The physician order dated 7/19/19 was to administer insulin 70/30 10 units subcutaneous two times a day and hold for blood sugar less than 100, scheduled at 6:00 a.m., and 4:30 p.m. A sliding scale insulin order dated 6/18/19 was to administer Novolin R before meals and at bedtime as follows: 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, notify MD of blood sugar greater than 400. The Medication Administration Records (MAR) from 8/26/19 through 9/4/19 were reviewed. The August and September MAR's coded the resident as refusing the 6:00 a.m., insulin on 8/28/19 and 9/3/19, and refusing the required sliding scale insulin coverage of 2 units before bedtime on 8/27/19. During the pre-exit survey conducted on 9/5/19 the above findings was shared with the Administrator, the Corporate Nurse and the Director of Nursing. When asked if the care plan should have been revised to include the refusals of insulin, the Corporate Nurse stated, " I agree, we should have revised it (the care plan)."	{F 657}	5. 9.18.2019	
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	{F 658}		9/18/19

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{F 658}	Continued From page 3 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to follow physician orders for the administration of insulin for 1 of 15 residents in the survey sample, Resident # 105. The findings included: Resident #105 was admitted to the facility on 12/15/18 with diagnosis to include, but not limited to diabetes. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 8/16/19 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident was coded as having received insulin 7 out of 7 days in the look back period. Section E. Behaviors did not code the resident as having rejection of care to include taking medications. The resident's person-centered comprehensive care plan dated 5/14/19 identified a focus area of diabetes and the resident was at risk for low and/ or high blood sugar. The goal was that the resident would be free of low and or high blood sugars through the next review date of 11/14/19. One of the interventions listed to achieve/maintain the goal was to administer medications as ordered.	{F 658}	1. MD made aware of resident #105 refusing insulin and new insulin schedule obtained. 2. 100% audit of current residents with orders for blood sugars or insulin to identify others at risk for this issue. 3. Education by DON or designee for licensed nursing staff on updating, notifying MD regarding refusal of care, medications and treatment and documenting the notification and follow through. 4. Audit by DON or designee 5 times a week x 12 weeks on refusals of care, medication or treatments to ensure MD is notified. 5. 9.18.2019	

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{F 658}	Continued From page 4	{F 658}		

The physician order dated 7/19/19 was to administer insulin 70/30 10 units subcutaneous two times a day and hold for blood sugar less than 100, scheduled at 6:00 a.m., and 4:30 p.m. A sliding scale insulin order dated 6/18/19 was to administer Novolin R before meals and at bedtime as follows: 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, notify MD of blood sugar greater than 400.

The Medication Administration Records (MAR) from 8/26/19 through 9/4/19 were reviewed. The August and September MAR's coded the resident as refusing the 6:00 a.m., insulin on 8/28/19 and 9/3/19, and refusing the required sliding scale insulin coverage of 2 units before bedtime on 8/27/19. There is no evidence that the staff notified the physician of the residents refusals of these doses. There were blank entries for the administration of the 6:00 a.m., doses of 10 units of 70/30 insulin on 9/1/19 and 9/2/19, and a X for the entry for 9/4/19.

During the pre-exit survey conducted on 9/5/19 the above findings was shared with the Administrator, the Corporate Nurse and the Director of Nursing. The Director of Nursing stated, "We did find it in the audit that the insulin was not given...we gave immediate education to the nurses". The DON provided the Inservice education that was dated for a 6:00 a.m., missed dose of insulin for 8/23/19. The DON presented eMAR-shift Level Administration Notes from the night shift nurse dated 9/1, 9/2 and 9/4 that indicated the resident had refused the 6:00 am insulin stating he will take it with breakfast. There was no evidence that these doses were administered with breakfast on those days.

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F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to conduct a physician ordered lab test (urinalysis) for one resident (Resident #102) of 15 residents in the survey sample. The findings included: Review of Resident #102's clinical record revealed a physicians order dated 6/28/18 for a urinalysis however the record did not indicate the lab test was conducted as ordered by the physician. Resident #102's original admission date was 3/09/2019 and readmission date of 4/09/2019, with diagnoses including: chronic kidney disease, stage 3, anemia in chronic kidney disease, adult failure to thrive, benign prostatic hyperplasia without lower urinary tract symptoms, unspecified dementia without behavioral disturbance. Resident #102 was admitted to hospice on	F 773	1. Resident #102 no longer resides at this facility. 2. 100% audit of current residents with lab orders for last 30 days to ensure labs were drawn and the results were obtained to identify other residents at risk for this issue. 3. Education for licensed nursing staff by DON or designee on obtaining labs as ordered and ensuring results are in the medical record for review by the physician. This will include documentation of above. 4. Audit and review during clinical morning meeting of labs orders and results 5 times x week x 12 weeks by DON or designee. 5. 9.18.2019	9/18/19

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F 773	Continued From page 6	F 773		

6/7/2019.

Resident #102's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 6/14/2019. Resident #102 was coded as having severe cognitive impairment scoring 2 out of possible 15 on the BIMS (brief interview for mental status) exam. Rejection of care was coded at 1 (occurred 1 to 3 days). Toilet use was assessed at 4 (total dependence on staff). Personal hygiene was assessed at 4 (total dependence on staff). Urinary and bowel continence were assessed at 3 (always incontinent).

Resident #102's comprehensive care plan indicated Resident #102 at risk for infection R/T (related to) hx (history) of UTI (urinary tract infection), initiated on 3/11/2019, with goals to develop less UTI's through next review and Site will be free from s/s of infection through next review. Interventions were: Monitor for mood changes R/T isolation and report to physician; Report S/S of infection to MD; Assess for s/s of UTI: foul smelling urine, cloudy urine, sediment, decreased output; assess for pain and medicate per order.

Review of facility's progress note documentation revealed the following:

6/28/2019 at 14:40 (2:40 PM) "Resident's daughter was requesting he be tested for a UTI. Called (Name of hospice company) and left message for her to call us back. Awaiting call."
6/28/2019 at 15:56 (3:56 PM)-Order detail read: "Per Hospice doctor please straight cath resident for UA/CNS"

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F 773	Continued From page 7	F 773		

6/28/2019 at 15:58 (3:58 PM) Nursing note read: "received call back form (SIC) hospice and their doctor ordered a UA/CNS to rule out UTI. May straight cath (catheter) to obtain specimen.

An interview conducted with Administrative Staff #3, Regional Nurse Consultant, on 9/5/2019 at 8:48 a.m. and she was asked about the disposition of the 6/28/2019 order for labs. She stated "UA was ordered on 6/28/2019 per physician order." Surveyor noted that there is no documentation indicating that a urine specimen was obtained. When asked what is the process to complete a physician's order, Administrative Staff #3 responded, "The nurse would attempt to obtain urine sample. The lab results will show up in the computer once ordered. It will pop up in the computer that lab needs to be done. It can take 24-48 hours to show in system. He was incontinent, non-compliant and uncooperative with people." She stated she called the lab for the results but they were unable to locate the results.

Review of clinical record indicated no documented evidence that the specimen was obtained. Additionally, there were no lab results from the 6/28/2019 lab order found within clinical record.

The Administrator was informed of the findings at the pre-exit meeting on 9/5/19. No additional information was provided by the facility staff.